Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

Ship To: 1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

CEMETERY BOARD

APPLICATION FOR CHANGE OF TRUSTEE OF A CARE FUND OR A PRENEED TRUST FUND

NO FEE REQUIRED

Purpose: To obtain written approval from the Board before transferring a care fund or a preneed trust fund from one financial institution to another. In this form "trustee" refers to the financial institution.

1. Name of Cemetery Authority and/or Preneed Seller (exactly as it appears on license)

2. Address of Principal Office (street, city, state, zip)

3. Daytime Telephone Number

___ - ___ - ____

4. Complete the following for one or more accounts to be transferred:

a. Name or Account Number of Account to be Transferred

b. Type of Fund

☐ Care Fund ☐ Preneed Trust Fund

c. Amount in Account which will be Transferred

d. Manner/Instrument by which Transfer is to be Made

AFFIDAVIT OF FINANANCIAL INSTITUTION FROM WHICH ACCOUNT WILL BE TRANSFERRED:

The undersigned, a duly authorized official of the _____ (Financial Institution),

at, _____ (Street), _____ (City), _____ (State),

on behalf of this institution, does swear and affirm that the information provided in 4a. through 4d. above is correct and that the institution is prepared to release the above-described account upon the approval of the Department of Safety and Professional Services.

Signature of Officer of Institution

Date

__ / __ / ____

Print or Type Name of Officer

Title

Wisconsin Department of Safety and Professional Services

4. Continued:

a. Name or Account Number of Account to be Transferred

b. Type of Fund

☐ Care Fund ☐ Preneed Trust Fund

c. Amount in Account which will be Transferred

d. Manner/Instrument by which Transfer is to be Made

AFFIDAVIT OF FINANANCIAL INSTITUTION FROM WHICH ACCOUNT WILL BE TRANSFERRED:

The undersigned, a duly authorized official of the _____ (Financial Institution),

at, _____ (Street), _____ (City), _____ (State)

on behalf of this institution, does swear and affirm that the information provided in 4a. through 4d. above is correct and that the institution is prepared to release the above-described account upon the approval of the Department of Safety and Professional Services.

Signature of Officer of Institution

Date

__ __ / __ __ / __ __ __ __

Print or Type Name of Officer

Title

a. Name or Account Number of Account to be Transferred

b. Type of Fund

☐ Care Fund ☐ Preneed Trust Fund

c. Amount in Account which will be Transferred

d. Manner/Instrument by which Transfer is to be Made

AFFIDAVIT OF FINANANCIAL INSTITUTION FROM WHICH ACCOUNT WILL BE TRANSFERRED:

The undersigned, a duly authorized official of the _____ (Financial Institution),

at, _____ (Street), _____ (City), _____ (State)

on behalf of this institution, does swear and affirm that the information provided in 4a. through 4d. above is correct and that the institution is prepared to release the above-described account upon the approval of the Department of Safety and Professional Services.

Signature of Officer of Institution

Date

__ __ / __ __ / __ __ __ __

Print or Type Name of Officer

Title

Committed to Equal Opportunity in Employment and Licensing

5. Reason for requesting the change of trustee:

6. Anticipated date the transfer is to be effectuated: ___/___/____

7. State any costs which will accrue to the balance of the care fund(s) or preneed trust fund(s) listed in #4 above upon the change of trustee and the nature and anticipated amounts of any service charges, administrative fees or other costs which will be imposed against the care fund(s) or preneed fund(s) by the propose trustee.

8. AFFIDAVIT OF FINANCIAL INSTITUTION TO WHICH ACCOUNT(S) WILL BE TRANSFERRED:

The undersigned, a duly authorized official of the _____ (Financial Institution),

at, _____ (Street), _____ (City), _____ (State)

on behalf of this institution, does swear and affirm that the information provided in 4a. through 4d. above is correct and that the institution is prepared to release the above-described account upon the approval of the Department of Safety and Professional Services.

Signature of Officer of Institution

Date ___/___/____

Print or Type Name of Officer

Title

Wisconsin Department of Safety and Professional Services

9. CERTIFICATION OF CEMETERY AUTHORITY:

CONTINUING DUTY OF DISCLOSURE:

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT:

I declare that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action. I affirm that the rights and interests of the beneficiaries of the fund(s) listed in #4 above will be adequately protected subsequent to this change of trustee.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature of Authorized Representative of Cemetery Authority

Date __ __ / __ __ / __ __ __ __

Print or Type Name of Authorized Representative

Title